STATE OF COLORADO
FY06 Colorado Health Plan Description Form -- Health Maintenance Organizations (HMOs)

San Luis Valley HMO	
PART A: TYPE OF COVERAGE	
1. TYPE OF PLAN	Health Maintenance Organization (HMO)
2. OUT-OF-NETWORK CARE COVERED? [1]	Only for emergency and urgent care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available only in the following counties: Alamosa, Conejos, Costilla, Mineral, Rio Grande, and Saguache
PART B: SUMMARY OF BENEFITS	
This form is not a contract. It is only a summary. The contents of this form are subject to provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.	
4. ANNUAL DEDUCTIBLE – Individual & family [2]	No Deductibles
5. OUT-OF-POCKET ANNUAL MAXIMUM [3] a) Individual b) Family	 a) $1,000 plus copays b) $3,000 plus copays
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$2,000,000 Lifetime maximum (See Transplants, Line #24)
7A. COVERED PROVIDERS	All physicians in the San Luis Valley six-county service area; approximately 1,300 specialty providers in Colorado; 17 Colo. hospitals. See provider directory for complete list.
7B. With respect to network plans, are all of the providers listed in 7A accessible to me through my primary care physician?	Yes
8. ROUTINE MEDICAL OFFICE VISITS [4] a) Primary Care b) Specialist	 a) $30 per visit copay-PCP b) $50 per visit copay-Specialist
9. PREVENTIVE CARE a) Children services b) Adult services	 a) $30 per visit copay-PCP; $50 per visit copay-Specialist b) $30 per visit copay-PCP; $50 per visit copay-Specialist
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care [5]	 a) $30 per visit copay-PCP; $50 per visit copay-Specialist b) $250 copay per day; up to maximum of 4 days per admission copay.
11. PRESCRIPTION DRUGS [6] Level of coverage and restrictions on prescription	After a $100 common prescription deductible:$10 copay for formulary generic; $25 copay for formulary brand name ; $50 copay for non-formulary brand name and non-formulary generic. Prescriptions are filled at the lesser of a 30-day supply or 100 unit dose. Two copays required for 90-day supply of maintenance drugs through mail order. 20% copay for injectables. For drugs on our approved list, excluded drugs and injectables subject to the 20% copay contact Customer Service. Not subject to out of pocket maximum.
12. INPATIENT HOSPITAL	$250 copay per day; up to maximum of 4 days per admission copay.
13. OUTPATIENT / AMBULATORY SURGERY (INVASIVE PROCEDURES INCLUDED HERE)	$200 copay per procedure.
14. DIAGNOSTICS a) Laboratory & X-ray b) MRI/CT/PET, nuclear medicine, and other high-tech services	 a) $20 copay + 10%, if not part of office visit. b) $75 copay per procedure.
15. EMERGENCY CARE [7, 8]	$100 copayment per visit (waived if admitted) Emergency Care covered in or out-of-network.
16. AMBULANCE	20% copay per trip. Not waived if admitted, not included in out-of-pocket maximum.

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17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$50 per urgent care visit copay ($100 if in emergency room) Urgent care may be received from your PCP or from an urgent care center. Care covered in or out-of-network.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE [9]	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE a) Inpatient Care b) Outpatient Care	 a) 50% copay (limited to 45 days) b) $30 copay per visit (limited to 20 visits) Maximum Plan Benefit is $1,000 per year
20. ALCOHOL & SUBSTANCE ABUSE a) Inpatient Care b) Outpatient Care	a) 50% copay (covered only for short term detoxification, rehabilitation not covered) Limited to one treatment per contract year, two treatments for lifetime. b) $30 copay per visit (limited to 20 visits) Maximum Plan Benefit is $1,000 per year
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Inpatient b) Outpatient	 a) $250 copay per day up to 4 days per admission copay. (Limited to 30 days per injury or illness) b) $30 per visit copay (limited to 30 treatments per injury or illness)
22. DURABLE MEDICAL EQUIPMENT	20% copay (benefit limited to $3,000 benefit payment per contract year, combined with oxygen benefit (line 23), except for prosthetic arms and legs that are not subject to the maximum benefit payment, but does reduce the maximum benefit payment of $3,000. Not subject to out-of-pocket maximum.
23. OXYGEN	20% copay (limited to $3,000 benefit payment per contract year, combined with durable medical equipment benefit (line 22) Not subject to out-of-pocket maximum.
24. ORGAN TRANSPLANTS	$250 copay per day, up to 4 days per admission copay. See policy for types and circumstances of coverage. $1,000,000 Lifetime Maximum Benefit on all transplant related services including drugs.
25. HOME HEALTH CARE	No copay (100% covered) when authorized. Limited to 30 visits per contract year.
26. HOSPICE CARE	No copay (100% covered) when authorized. Limited to 90 days per contract year.
27. SKILLED NURSING FACILITY CARE	No copay (100% covered) when authorized; limited to 30 days per contract year.
28. DENTAL CARE	No dental benefits are available under this medical plan. .
29. VISION CARE	$20 per visit copay limited to one visit every 24 months. Hardware not covered.
30. CHIROPRACTIC CARE	Not covered.

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31. SIGNIFICANT ADDITIONAL COVERED SERVICES	1. Free child car seat program for expectant mothers who meet eligibility criteria; 2. Smoking cessation program - $150 lifetime benefit; 3. Infertility Services: for diagnosis only - 50% copay. 4. **Cancer screening Coverage:** (as ordered by your physician) Cancer screening tests are covered as follows (subject to the applicable Health Benefit Plan deductibles, copay/coinsurance, referrals and maximum benefit levels): a) Breast Cancer Screening - Mammograms – single baseline mammogram for women ages 35 to 39 once during a five year period; once every two years for women ages 40 to 50; annually for women over 50; once a year for women with risk factors to breast cancer as determined by her Primary Care Physician. b) Cervical Cancer Screening – Annual pelvic exam and Pap Smear as age appropriate c) Colon Cancer Screening – age 50 and over are covered for two colorectal visualizations between ages 50 and 70. d) Prostate Cancer Screening – men age 50 and over are covered for annual PSA Blood test and digital rectal exam and men 40-49 years of age if at increased risk.
PART C: LIMITATIONS & EXCLUSIONS	
32. PERIOD DURING WHICH PREEXISTING CONDITIONS ARE NOT COVERED. [10]	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THIS POLICY DEFINE A"PRE-EXISTING CONDITION?"	Not applicable. Plan does not impose limitation periods for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier. Review them to see if a service or treatment you may need is excluded from the policy.
PART D: USING THE PLAN	
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	Yes
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
39. What is the main customer service number?	1-800-475-8466 or 1-719-589-3696
40. Whom do I write/call if I have a complaint or want to file a grievance? [11]	Complaint & Grievance Coordinator San Luis Valley HMO, Inc. 700 Main Street, Suite 100 Alamosa, CO 81101 1-800-475-8466 or 1-719-589-3696
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy Form SLV/SOC 7-2005 Large Group Only

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43. Does the plan have a binding arbitration clause?	Yes, to the extent permitted by law.
PART E: COST AND MEDICAL EXPENDITURES	
44. What is the cost for this plan? Employee only Employee + Spouse Employee + Child(ren) Employee + Spouse and Child(ren)	Final rates will be made available via the Benefits newsletter, *HealthLine*, and on the Benefits website www.colorado.gov/dpa/dhr.

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order to get any coverage at all under the plan, or that the plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

[2] "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or a contract year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible may be noted in boxes 8 through 31.

[3] Out-of-pocket maximum. The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximums may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.

[4] Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

[5] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments.

[6] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

[7] "Emergency care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed.

[8] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

[9] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[10] Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

[11] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

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